

		FOR OHF USE					

LL 1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0029645</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Crawford County Convalescent</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>June 1, 2003</u> to <u>May 31, 2004</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>902 Mefford</u> <u>Robinson</u> <u>62454</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Crawford</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(618) 546-5638</u> Fax # <u>(618) 544-7068</u>		Paid Preparer (Signed) <u>See Accountants' Compilation Report</u> _____ (Date) _____ (Print Name and Title) <u>Robert A. Disbrow</u> <u>Member</u> (Firm Name & Address) <u>Sleeper, Disbrow, Morrison, Tarro & Lively, LLC</u> <u>P.O. Box 1460, Decatur, IL 62525</u> (Telephone) <u>(217) 423-6000</u> Fax # <u>(217) 423-6100</u>	
IDPA ID Number: <u>37-11756262</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>06/15/1985</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Robert A. Disbrow</u> Telephone Number: <u>(217) 423-6000</u>			

STATE OF ILLINOIS

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Facility Name & ID Number Crawford County Convalescent# 0029645 Report Period Beginning: June 1, 2003 Ending: May 31, 2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>54</u>	Intermediate (ICF)	<u>54</u>	<u>19,764</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>54</u>	TOTALS	<u>54</u>	<u>19,764</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>12,293</u>	<u>2,547</u>		<u>14,840</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,293</u>	<u>2,547</u>		<u>14,840</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 75.09%

D. How many bed-hold days during this year were paid by Public Aid?

138 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
_____F. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 06/15/1985

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 06/15/1985 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 05/31/04 Fiscal Year: 05/31/04

* All facilities other than governmental must report on the accrual basis.

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Facility Name & ID Number

Crawford County Convalescent

0029645

Report Period Beginning:

June 1, 2003

Ending:

May 31, 2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	101,352	4,600	864	106,816		106,816		106,816		1
2	Food Purchase		61,823		61,823	(2,953)	58,870	(757)	58,113		2
3	Housekeeping	38,376	6,493		44,869		44,869		44,869		3
4	Laundry	18,225	3,822		22,047		22,047		22,047		4
5	Heat and Other Utilities			41,060	41,060		41,060		41,060		5
6	Maintenance	17,202	9,812	7,707	34,721	78	34,799	(611)	34,188		6
7	Other (specify):*										7
8	TOTAL General Services	175,155	86,550	49,631	311,336	(2,875)	308,461	(1,368)	307,093		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	350,665	8,500	32	359,197		359,197		359,197		10
10a	Therapy			450	450		450		450		10a
11	Activities	17,622	1,086	1,033	19,741		19,741		19,741		11
12	Social Services	19,425		1,033	20,458		20,458		20,458		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	387,712	9,586	8,548	405,846		405,846		405,846		16
	C. General Administration										
17	Administrative	126,600			126,600		126,600		126,600		17
18	Directors Fees										18
19	Professional Services			11,679	11,679		11,679		11,679		19
20	Dues, Fees, Subscriptions & Promotions			2,863	2,863		2,863	(1,262)	1,601		20
21	Clerical & General Office Expenses		7,907	6,277	14,184		14,184	(273)	13,911		21
22	Employee Benefits & Payroll Taxes			99,966	99,966	2,953	102,919	(19,147)	83,772		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,231	2,231		2,231		2,231		24
25	Other Admin. Staff Transportation			3,775	3,775	(448)	3,327		3,327		25
26	Insurance-Prop.Liab.Malpractice			82,757	82,757		82,757		82,757		26
27	Other (specify):*										27
28	TOTAL General Administration	126,600	7,907	209,548	344,055	2,505	346,560	(20,682)	325,878		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	689,467	104,043	267,727	1,061,237	(370)	1,060,867	(22,050)	1,038,817		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number

Crawford County Convalescent

#0029645

Report Period Beginning:

June 1, 2003

Ending:

May 31, 2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			26,880	26,880		26,880	1,799	28,679			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,320	7,320		7,320	(661)	6,659			32
33	Real Estate Taxes			11,611	11,611		11,611	(1,360)	10,251			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax			(473)	(473)		(473)	473				36
37	TOTAL Ownership			45,338	45,338		45,338	251	45,589			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					370	370		370			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			2,768	2,768		2,768		2,768			41
42	Provider Participation Fee			29,646	29,646		29,646		29,646			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			32,414	32,414	370	32,784		32,784			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	689,467	104,043	345,479	1,138,989		1,138,989	(21,799)	1,117,190			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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Facility Name & ID Number Crawford County Convalescent

0029645

Report Period Beginning:

June 1, 2003

Ending:

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(129)	2		4
5	Telephone, TV & Radio in Resident Rooms	(611)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,799	30		9
10	Interest and Other Investment Income	(661)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(628)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(273)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(125)	20		20
21	Owner or Key-Man Insurance	(19,147)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,137)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	473	36		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Rental Prop R/E Taxes	(1,360)	33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (21,799)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (21,799)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	X		\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Crawford County ConvalescentID# 0029645Report Period Beginning: June 1, 2003Ending: May 31, 2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Rental Prop R/E Taxes	\$ (1,360)	33	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,360)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Crawford County Convalescent

0029645

Report Period Beginning:

June 1, 2003

Ending:

May 31, 2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(757)	0	0	0	0	0	0	0	0	0	0	(757)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(611)	0	0	0	0	0	0	0	0	0	0	(611)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,368)	0	0	0	0	0	0	0	0	0	0	(1,368)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,262)	0	0	0	0	0	0	0	0	0	0	(1,262)	20
21	Clerical & General Office Expenses	(273)	0	0	0	0	0	0	0	0	0	0	(273)	21
22	Employee Benefits & Payroll Taxes	(19,147)	0	0	0	0	0	0	0	0	0	0	(19,147)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(20,682)	0	0	0	0	0	0	0	0	0	0	(20,682)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(22,050)	0	0	0	0	0	0	0	0	0	0	(22,050)	29

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Dwight Miller	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 2003 Ending: May 31, 2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Dwight Miller	President	Administrative	100.00	0	40	100.00	Wages	\$ 106,600	17.1	1
2	Ardella Miller	Vice-President	Administrative	100.00	0	40	100.00	Wages	20,000	17.1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 126,600		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 2003 Ending: ay 31, 2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Dwight Miller	X		Facility Purchase	-	06/15/99	\$ 61,000	\$ 61,000	06/15/04	12.0000	\$ 7,320	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 61,000	\$ 61,000			\$ 7,320	9	
	B. Non-Facility Related*												
10	Interest Income										(661)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (661)	14	
15	TOTALS (line 9+line14)						\$ 61,000	\$ 61,000			\$ 6,659	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ - Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Crawford County Convalescent COUNTY Crawford

FACILITY IDPH LICENSE NUMBER 0029645

CONTACT PERSON REGARDING THIS REPORT Dwight Miller

TELEPHONE (618) 546-5638 FAX #: (618) 544-7068

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>05-4-28-030-010-000</u>	<u>902 W. Mefford</u>	\$ <u>9,804.80</u>	\$ <u>9,804.80</u>
2. <u>05-4-28-030-010-001</u>	<u>902 W. Mefford</u>	\$ <u>1,138.76</u>	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>10,943.56</u></u>	\$ <u><u>9,804.80</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

A.

Square Feet:

11,086

B.

General Construction Type:

Exterior

Masonry

Frame

Steel

Number of Stories

1

C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	31,150	1985	\$ 10,000	1
2					2
3	TOTALS	31,150		\$ 10,000	3

Facility Name & ID Number Crawford County Convalescent

0029645

Report Period Beginning:

June 1, 2003 Ending: May 31, 2004

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	54		1985	1971	\$ 558,630	\$ 16,333	30	\$ 18,621	\$ 2,288	\$ 353,799	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Storage Building		1985		2,500		20	125	125	2,375	9
10	Improvement		1985		8,536	427	20	427		7,966	10
11	Hall Remodel		1986		1,238	62	20	62		1,129	11
12	Air Conditioner		1987		5,775	289	20	289		4,933	12
13	Lobby Remodel		1985		2,965		10			2,965	13
14	Office-House		1985		15,000	750	20		(750)	7,500	14
15	Generator		1988		12,182	609	20	609		9,644	15
16	Reroof Building		1989		17,110	856	15	856		17,110	16
17	Air Conditioner		1989		6,400		10			6,400	17
18	Hall Remodel		1990		2,568		10			2,568	18
19	Storage Building		1992		7,114	474	10	474		5,494	19
20	Storage Building-Additions		1993		2,170	145	15	145		1,591	20
21	Roof-North Wing		1995		9,376	625	15	625		5,782	21
22	Electromagnetic Locks		1996		6,412	641	10	641		5,397	22
23	Window Replacements		1996		8,478	565	15	565		4,192	23
24	Automatic Doors		1998		4,975	332	15	332		1,907	24
25	Plumbing Repairs		2004		1,537	26	15	26		26	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 672,966	\$ 22,134		\$ 23,797	\$ 1,663	\$ 440,778	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 31,500	\$ 3,034	\$ 3,170	\$ 136	10	\$ 20,606	71
72	Current Year Purchases	2,174	182	182		10	182	72
73	Fully Depreciated Assets	124,174					124,174	73
74								74
75	TOTALS	\$ 157,848	\$ 3,216	\$ 3,352	\$ 136		\$ 144,962	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Staff Transportation	1997 Ford Escort	2000	\$ 7,650	\$ 1,530	\$ 1,530	\$	4	\$ 7,140	76
77	Resident Transportation	Handicap Lift Bus	1990	7,500				4	7,500	77
78										78
79										79
80	TOTALS			\$ 15,150	\$ 1,530	\$ 1,530	\$		\$ 14,640	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 855,964	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 26,880	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 28,679	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,799	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 600,380	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO </p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
10	Academic Education		hrs							11
11	Exceptional Care Program									12
12	Other (specify):									13
13										
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 38,451	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	263,187		3
4	Supply Inventory (priced at <u>Cost</u>)	4,626		4
5	Short-Term Investments			5
6	Prepaid Insurance	38,437		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Tax Refund Receivable</u>	2,858		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 347,559	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,000		13
14	Buildings, at Historical Cost	604,333		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	215,479		16
17	Accumulated Depreciation (book methods)	(606,913)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Tax Deposit</u>	18,785		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 266,684	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 614,243	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 41,837	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	24,538		30
31	Accrued Taxes Payable (excluding real estate taxes)	49,386		31
32	Accrued Real Estate Taxes(Sch.IX-B)	15,406		32
33	Accrued Interest Payable	7,320		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 138,487	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	61,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 61,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 199,487	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 414,756	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 614,243	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 437,441	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 437,441	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(22,685)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (22,685)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 414,756	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,112,429	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,112,429	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,837	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	129	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,966	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	661	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 661	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Parking Lot Rental</u>	180	28
28a	<u>Miscellaneous</u>	68	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 248	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,116,304	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	311,336	31
32	Health Care	405,846	32
33	General Administration	344,055	33
	B. Capital Expense		
34	Ownership	45,338	34
	C. Ancillary Expense		
35	Special Cost Centers	2,768	35
36	Provider Participation Fee	29,646	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,138,989	40
41	Income before Income Taxes (line 30 minus line 40)**	(22,685)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (22,685)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Crawford County Convalescent# 0029645Report Period Beginning: June 1, 2003Ending: May 31, 2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,040	2,080	\$ 47,003	\$ 22.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,120	4,216	59,356	14.08	3
4	Licensed Practical Nurses	4,337	4,361	53,561	12.28	4
5	Nurse Aides & Orderlies	25,087	25,391	190,745	7.51	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,933	2,117	17,622	8.32	9
10	Activity Assistants					10
11	Social Service Workers	1,958	2,062	19,425	9.42	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,299	2,347	34,538	14.72	14
15	Cook Helpers/Assistants	10,903	11,031	66,814	6.06	15
16	Dishwashers					16
17	Maintenance Workers	2,023	2,255	17,202	7.63	17
18	Housekeepers	5,912	6,104	38,376	6.29	18
19	Laundry	2,144	2,264	18,225	8.05	19
20	Administrator	2,080	2,080	106,600	51.25	20
21	Assistant Administrator	2,080	2,080	20,000	9.62	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	66,916	68,388	\$ 689,467 *	\$ 10.08	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	48	\$ 864	1.3	35
36	Medical Director		6,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	8	400	10A.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		50	10A.3	43
44	Activity Consultant	16	1,033	11.3	44
45	Social Service Consultant	16	1,033	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	87	\$ 9,380		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Dwight Miller	Administrative	100	\$ 106,600
Ardella Miller	Asst. Admin.	100	20,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 126,600
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
A Better Way	Payroll		\$ 550
Sleeper, Disbrow, et al	Accounting		4,040
Duane Morris	Legal		7,089
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 11,679
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 19,873
Unemployment Compensation Insurance			6,536
FICA Taxes			50,394
Employee Health Insurance			3,427
Employee Meals			2,953
Illinois Municipal Retirement Fund (IMRF)* Christmas			589
TOTAL (agree to Schedule V, line 22, col.8)			\$ 83,772
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			142
Health Care Worker Background Check (Indicate # of checks performed _____)			
Dues			534
Subscriptions			925
Less: Public Relations Expense		(
Non-allowable advertising		(
Yellow page advertising		(
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 1,601
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			1,324
Seminar Expense			907
Entertainment Expense		(
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 2,231

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Nursing Adm Assoc \$30 & IL Act Prof Assoc\$30
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 8 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 29,646
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 2,953 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 129
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 10%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.